The Audit Unit audits Medicaid providers and non-Medicaid providers enrolled in Medicaid managed care organizations (MCOs), to ensure compliance with program requirements and to identify overpayments. These audits allow the MFD to monitor the cost-effectiveness of Medicaid services, as well as providers engaged in committing fraud and abuse within the Medicaid program.

The MFD Audit Unit not only audits provider services within the Medicaid program but also coordinates, oversees, and reviews the audit work of other State agencies and/or third-party contractors. For example, in fiscal year 2011, MFD began reviewing the pharmacy and durable medical equipment (DME) audits performed by a third party vendor that contracted with the Division of Medical Assistance and Health Services (DMAHS) within the Department of Human Services (DHS).

The Medicaid program requires participating providers to maintain adequate records to support their claims. For example, cost-based providers must maintain financial and statistical records which are used for the purpose of establishing reimbursement rates. Providers who participate through MCOs must maintain records in accordance with the contract language between the MCOs and DMAHS, and abide by all applicable state and federal laws and regulations, regardless of whether they are actually Medicaid providers. Fee-for-service providers, who are paid in accordance with DMAHS-established rates, fees, and schedules, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the Medicaid program. Regardless of whether a provider is enrolled in Medicaid or only enrolled as a provider in a Medicaid managed care plan, it must maintain all records necessary to disclose the nature and

extent of services or equipment furnished and its medical necessity, including any prescription or fiscal order for the service or equipment, for a period of five years from the date the care, services or supplies were furnished or billed, whichever is later.

The MFD Audit Unit has created this Guide Book to assist providers in understanding the Audit process.

Selection of Audit Subject Areas, Providers and Methods

The MFD uses a variety of analytical tools and data mining techniques to identify providers for audits. MFD's Audit Unit conducts a risk assessment analysis as well as considers successful initiatives employed in other states, current academic and public policy organizational analyses of health care issues, and program ideas and directives from the federal Centers for Medicare and Medicaid Services (CMS) and from the US Department of Health and Human Service, Office of Inspector General (OIG). MFD Auditors work closely with the Departments of Human Services, Health and Senior Services, and Children and Families to identify potential vulnerabilities in the Medicaid programs they administer.

Providers are selected for audit utilizing a variety of risk factors including, but not limited to: a) Medicaid dollars billed on a yearly basis; b) provider type; c) significant change in Medicaid billings on a year-to-year basis; d) complaints from the public; e) providers subject to Corrective Action Plans or Corporate Integrity Agreements; f) CMS and OIG alerts regarding fraud and abuse taking place in other states' Medicaid and/or Medicare programs; g) program vulnerabilities identified from previous audits or investigations; h) length of time since a previous audit or investigation took place; i) services billed which are particularly vulnerable to fraud, abuse, or waste; and j)

weaknesses identified in the State's Medicaid regulations.

Prior to the Audit team conducting an on-site audit, MFD will send a letter alerting the provider that it will be audited, the scope of the audit, the length of the audit, the authority for the audit, and the date of the entrance conference. The entrance conference consists of a meeting with each individual provider to discuss in more detail the nature and extent of the audit.

Upon completion of a field audit, MFD will conduct an exit conference with the provider to discuss preliminary findings. Afterward, the MFD will issue its draft audit report which will identify any proposed recovery and the basis for the action, internal control weaknesses, and recommendations to address these weaknesses. The provider has 10 business days to respond to the draft audit report. If the provider fails to respond within that time frame, the report will become final within the subsequent five business days and be issued at that time. If the provider objects to the draft audit report, the MFD will evaluate the provider's response, and any supporting documentation submitted by the provider, before issuing a final report. Under these circumstances, the final audit report will be issued within 30 days from the exit conference. MFD's next step in recovering overpayments is discussed in a subsequent section.

If the Audit team uncovers fraudulent activity during the course of its field audit, they will immediately refer their findings to the MFD's Investigation Unit for further review and investigation.

The Audit team utilizes both statistical and non-statistical sampling techniques to gather its sample population for a given audit scope. These techniques, which are discussed in more detail below, enable a reasonable conclusion to be drawn

regarding the entire population based on the audit findings of the sample population.

Statistical Probability Sampling:

Probability sampling methods include: simple random sampling, systematic sampling, stratified sampling, and cluster sampling. For each of these methods, each unit within the population has a known non-zero probability of being included in the sample. The advantages of these methods give high degree of representativeness and the ability to calculate a sampling error. When a sampling error can be calculated, a confidence interval can be determined.

Simple random sampling involves using a random selection to draw a fixed number of sampling units from the data without replacement (one unit cannot be used more than once). This method ensures that each set of sampling units has the same probability of selection from any other set.

Systematic sampling requires that the population be numbered in order (from 1 to the end). A random start is used and the next unit is selected using a fixed interval (i.e., if one starts with the number 5 and uses an interval of 10, the next data to be a part of the sample is number 15, then 25, 35, etc.) until the end of the population is reached.

The stratified sampling method is done by grouping the population into non-overlapping strata. Random samples are selected from each of the strata to obtain an unbiased estimate while reducing the margin of error.

Cluster sampling involves drawing a random sample of clusters and reviewing either all units or a sample of units selected from each of the sampled clusters. Unlike strata, the clusters are groups that might not have strong similarities.

Non-statistical Probability Sampling:

Non-statistical probability sampling includes haphazard sampling, block selection, and judge selection. Using the haphazard sampling method, the auditor selects the sample items without bias to include or exclude certain items in the population. It represents the auditor's best estimate of a representative sample. Block selection is performed by applying audit procedures to items, such as claims, that occurred in the same "block" of time. Judgment sample selection is based on the auditor's judgment. It is used when only a specific area within the population is under auditor scrutiny or timely information is required.

The confidence level measures the reliability of the estimates when doing statistical probability sampling. Non-statistical probability sampling does not provide a measurement of sampling risk, thus, confidence interval measurements do not pertain to this category of sampling. A confidence interval is expressed by a percentage (i.e., 90% confidence interval). For example, an auditor can be "99 percent confident" that the mean of the items within the sample fall between two values, M1 and M2, which are the upper and lower bounds of the confidence interval.

Recovery

Our Recovery and Exclusion team recovers overpayments identified by the MFD auditors and investigators. Additionally, the team determines when to exclude a Medicaid provider from the program. The primary goals of Recovery and Exclusion are twofold: 1) to take an active approach to recover overpayments from providers and recipients; and 2) determine whether providers who failed to adhere to the Medicaid program regulations should be excluded from the program. This team has a number of tools at its disposal to achieve these goals.

Where MFD has identified an overpayment, the Recovery and Exclusion team may, under certain circumstances, withhold payments to a Medicaid provider until an overpayment is recouped. In other circumstances, the Medicaid provider may make payment arrangements with MFD. For a recipient who received Medicaid benefits when not entitled to them, the team may file a Certificate of Debt on the recipient's property so that the state can receive its share of monies should the recipient sell his or her property.

Pursuant to federal law, DMAHS is obligated to repay the federal government its proportionate share of recovery within one year of properly identifying the amount of recovery. The Recovery and Exclusions team follows the protocol outlined below in seeking recoupment.

Recoupment Protocol

If the MFD Audit Unit determines that the provider overbilled the Medicaid program, the team will issue a final audit report, putting the provider on notice of the amount owed. When a final audit report is issued, the case will be referred to the Recovery and Exclusions team, which will immediately issue a Notice of Claim to the provider identifying the amount owed. When a Notice of Claim is issued to an entity, the entity has 20 days to request a pre-hearing conference with the MFD Recovery and Exclusion team to resolve the amount of the claim. If the pre-hearing conference results in the proper claim amount being agreed upon by both the entity and the MFD, the MFD will recover the overpayment.

Similarly, where the MFD identifies an amount of money owed by a provider resulting from an investigation by the Investigations Unit, the Recovery and Exclusion team will issue a Notice of Claim to the provider identifying the amount owed. When a

Notice of Claim is issued to an entity, the entity has 20 days to schedule a pre-hearing conference with the team to resolve the amount of the claim. If the pre-hearing conference results in the proper claim amount being agreed upon by both the entity and the MFD, then MFD will recover the overpayment.

If the pre-hearing conference process does not result in a mutually agreed upon claim amount, then within five days from the end of that process, the MFD will send a Notice of Demand to the entity. The entity has 20 days from the date of the Notice of Demand to schedule an administrative hearing with the Office of Administrative Law (OAL). If the entity does not schedule a hearing, MFD reserves the right to withhold payment up to 100 percent of the amount listed on the Notice of Demand (if a provider), or file a Certificate of Debt against the recipient's property. Additionally, the claim against the provider is considered identified and final, and DMAHS is obligated to reimburse the federal government its portion of the claim.

If a request for a hearing is filed, an Administrative Law Judge (ALJ) will conduct a hearing and make a determination of the proper amount of the claim. Once the OAL Judge determines the amount of the claim, DMAHS will make a Final Agency Decision (FAD) either affirming or denying the OAL determination. If the FAD affirms the amount of the claim, the Recovery and Exclusions team will proceed with recovery and share the proportionate share with the federal government within the allotted time.*Questions*

The Medicaid Fraud Division looks forward to a successful year of combating Medicaid fraud, waste, and abuse. If you have any questions about the Medicaid Fraud Division's Audit Unit, please contact:

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or submit a form electronically through our website:

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